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ABSTRACT

This publication identifies information and resources on career development activities in the drug abuse field. The articles provide: (1) a discussion of professionalism of the drug abuse field; (2) an update on state-by-state credentialing; (3) a report of reciprocity agreements that aid credentialing efforts; and (4) a description of primary health care provider training workshops. A cumulative index by subject and author is included that places all articles written in the Drug Program Review since 1972 under alphabetized subject headings and categories. (NRB)

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DRUG PROGRAM REPORT

Career Development

April 1981

Jerome A. Contee, Ed.

U.S. DEPARTMENT OF EDUCATION
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PREFACE

Drug Program Report (DPR), developed by the Career Development Center (CDC), is a publication that provides the Center with a formal mechanism for sharing information and resources on career development activities in the drug abuse field.

The Career Development Center operates under a contract awarded to HCS, Inc., by the National Institute on Drug Abuse (NIDA). The primary goal of CDC is to serve the field of drug abuse, the Institute and the National Training System by providing the highest quality of technical service and by developing exemplary resources to enhance the career mobility and recognition of traditional and non-traditional drug abuse professionals.

The CDC contract includes a number of specific tasks that foster the achievement of this goal. For example, the Center looks forward to:

- Providing expert technical assistance to States on credentialing issues
- Conducting regional workshops on credentialing, certification, career development, negotiating skills, and portfolio development
- Providing technical assistance to the National Drug Abuse Center (NDAC), the Regional Support Centers (RSCs), and to the states on National Training System course credit and curriculum innovations
- Providing staff services to national and state drug abuse conferences
- Coordinating the American Council on Education review and accreditation of national and state-developed courses
- Providing assistance to individuals and institutions on academic credit and negotiating advanced standing

Drug Program Report is the nucleus of the Center's publication efforts. Through the publication of DPR the Center will strive to enhance and increase:

- The understanding and use of career development strategies on the part of drug abuse workers
- The capability of states to design, implement, evaluate and modify certification systems
- The utilization of Career Development Center (CDC) services to National Training System components, particularly the Regional Support Centers and the State Training Support Programs
- The academic linkages between state training systems and local colleges and universities

The ability of Drug Program Report to play a resource role for the drug abuse field is of critical importance. In the coming year there will be far fewer face-to-face meetings among National Training System components and related agencies on both a regional and national basis. Given this reduction in opportunities for us to share and learn from each other, there is an even greater reliance on publications such as Drug Program Report.

Finally, Drug Program Report will be presenting a consistent format that keeps DPR readers updated concerning specific career development issues that are of interest to the field, such as credentialing and reciprocity. Most important, we would like to solicit your response and comments on articles. Please feel free to write and share your knowledge with us.

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PROFESSIONALISM OF THE DRUG ABUSE FIELD

by Lonnie E. Mitchell, Ph.D.

An Historical Overview

The National Institute on Drug Abuse maintains its concern for the credentialing of drug abuse workers for two reasons. First, persons receiving drug services deserve the highest quality of care. Second, the persons responsible for delivering that care should have the necessary competencies to deliver quality care. If these two concerns are met, then the traditional forms of credentialing, i.e., licensing and certification, become processes for recognition of these competencies.

All Institute efforts around the implementation of credentialing efforts have been carried out on a partnership arrangement with States. The Institute's role has been to support the identification of job functions and the skills associated with these functions through a series of efforts involving a number of State developed task forces. This was first done under contract to University Research Corporation in 1976-1979 when the functions performed by both drug and/or mental health workers were identified in a total of 13 different States (7 States for drugs and 6 for mental health). Due to the general nature of job functions, a further effort was necessary to identify the skills and knowledge needed to perform the functions. This activity was carried out under contract to the Medical College of Pennsylvania in 1976-1977. In this effort, six State Task Forces carried out task analyses of workers in order to identify skills related to various job functions. Six additional States and a special Minority Task Force reviewed the task analysis data for accuracy and validity. All task forces included a number of constituents from State employees to direct service deliverers, as well as, underserved populations (women and racial/ethnic minorities).

The result of this contract effort included:

- a listing of job functions (URC data and other functional data from State and other functional efforts);
- task descriptors (skills) related to a large number of the functions identified;
- and a series of implementation models for using the functional/skill data.

These products were immediately distributed to every State Agency and a program for training and technical assistance to States in the use of these materials was established through a work order agreement with Stanford Research International.

Two workshops, with six States in each and representatives from each NIDA Regional Support Center, were held in late 1977. The purposes of these workshops were:

- to develop State skills in the utilization of task analysis procedures;
- and to identify through action plans specific technical assistance needs around the utilization of the function/skill data.

It must be stressed at this point that the utilization of the function/skill data involves much more than State establishment of a certification/licensing program.

The models outlined involve data concerning:

- staff development through career ladders and performance evaluation procedures through specification of service functions;
- training and education evaluation through specification of job skills;
- development of alternative measures/demonstrations of job skills such as portfolios and simulations;
- and certification programs that relate more closely to job skills than formal academic preparation.

While the implementation of these models offers the basis for NIDA credentialing priorities during the coming year; the final uses of the function/skill products will depend upon the structure of the State Agency.

Professionalism: Rationale and Meaning

Drug abuse workers, too often and for too long, have been identified as "Para-Professionals" and "Preprofessionals." A central belief of the National Training System (NTS) is that anyone who is employed in the complex and sensitive task of treating drug abuse is a professional. The sophisticated combination of knowledge and skills required for the job justifies this distinction. Unfortunately, drug abuse workers, in the main, have not yet received either the recognition or the salary that is commensurate with professional status.

One problem that has been exceedingly difficult has been the inability of the field to arrive at consensus about what sets of qualifications define a professional drug abuse worker. A part of this problem has been the diversity found among treatment centers and their personnel. As a consequence State credentialing legislation differs widely from State to State. Additionally critical factors such as eligibility for third-party payments will depend on whether the workers in a given program can meet credentialing requirements of the States in which they are employed.

The NTS, in itself, cannot resolve all of the conundrums involved in charting a course for the evolution of professionalism in the drug abuse field. Pressures toward professionalism are coming from several disparate areas:

State legislators involved in credentialing legislation;

third-party payers who require precise definitions of drug abuse worker qualifications for establishing fee reimbursement schedules;

and perhaps most important, from the underpaid and underrecognized drug abuse workers themselves.

The work areas delineated under the 14 functional categories of NTS management (training, training of trainers, cross cultural adaptation, etc.) have a common purpose, the enhancement of professionalism and the establishment of professional recognition for drug abuse workers. Recognition that will be commensurate with the professional work they perform every day in treatment centers across the nation.

The term "professional" additionally refers to individuals being documented in some way to demonstrate that they have a minimum level of mastery over an identified body of knowledge, skills, and values, which are utilized in the service of clients. The client needs this service to deal with some kind of problem that he or she experiences physically or emotionally (in relation to social institutions), or in some combination thereof. Examples of such professionals include doctors, nurses, social workers, etc. These are people with academic degrees or licenses, which attest to the assumption that they are competent in practicing their specified skills. Further, many professionals such as orthopedic surgeons and psychiatric nurses, apply their skills to a particular problem area and specialize in developing unique skills, knowledge, and values which are then utilized in the problem areas.

Mental health is an excellent example of an area that has not only impacted on the traditional professions, but which has also spawned new professionals who are defined by the length of time they've spent in the problem area rather than by having a link with a recognized professional discipline. Medicine, nursing, social work, and psychology have recognized the specialities and problem areas in mental health. In addition, psychiatric technicians have appeared in some parts of the country over the past decade, as a new, nondisciplined mental health profession to provide a narrowly-defined range of services to psychiatric patients. Their knowledge, skills, and values are quite different from those of traditional disciplines of mental health. But they exist because a manpower need arose in certain psychiatric settings.

Drug abuse is an issue-specific problem area with medical, legal, and psychological parameters, which define the problem and society's responses to it. Drug-abusing clients may receive services from a broad spectrum of programs and agencies. These include general medical and mental health care facilities, where the client with a drug abuse problem may be treated as part of his or her overall health care by members of drug care professions. Legal services and social services may also be provided to an individual client, to assist him or her in dealing with various social systems and institutions. At the other end of the spectrum are the categorical drug abuse programs, which aim specifically at solving the client's drug abuse problem and then at subsequent rehabilitation. The people who deliver services in health care facilities or legal and social service agencies are

typically traditional professionals with academic degrees and recognized competencies in a particular discipline. However, their formal, academic training seldom prepares them to apply their skills to the problems of their drug abusing clients. In order to ensure that their work with these clients is professional and competent, it is necessary to include in academic curricula and in continuing education programs, courses in the recognition and treatment of drug abuse. Such a strategy requires outreach from professional groups and educational institutions and, sometimes the overcoming of resistance in the development and inclusion of new substance abuse oriented curriculum areas.

These problems are real, but certainly not insurmountable. A far more complicated problem exists among the staff of categorical drug abuse problems, most of which developed within the past 10 to 15 years. Typically, in the proliferation caused by the government's massive war on drugs, drug abuse workers--those people who work directly with drug abuse clients in treatment and rehabilitation--are frequently people with little formal or academic training, or no credentials. They have often been minority group members and ex-drug addicts who, by virtue of their personal experience, have turned to helping others like themselves. Typically, they work with clients whose special needs are not met by the mainstream of the health and social service delivery system. Many of these workers began with the unique knowledge gained from their experience, and then developed and mastered the skills they needed as they worked on the job.

Their body of knowledge was not formal. Training, when it occurred, was aimed at developing the competency of the worker to help the client. The drug abuse worker has, in many instances, not achieved the status of a professional, either in the traditional sense of a credentialized discipline, or in the sense of a recognized, competent speciality. They have often been considered non-professionals with inadequate training and education. In addition, the area of drug abuse itself was long considered to be a non-health problem, associated more with criminal behavior and severe social deviance. As a result, drug abuse services have historically, not been reimbursed by group health care insurance programs. In short, the drug abuse field has not been able to overcome its isolation from the mainstream of health and social service systems.

To complicate matters even further, changes in funding sources and manpower distribution are currently being contemplated, which will significantly impact on the status of drug abuse workers. For example, the availability of special categorical funds from State and Federal governments is decreasing. Additionally, in order to qualify for reimbursement from third party health insurance carriers, drug abuse treatment programs must meet the standards of the Joint Commission on Accreditation of Hospitals (JCAH). These standards tend to require that services be delivered by a degreed professional or by people with equivalent training or experience. As a consequence, third-party payers will probably dictate the development of standards to define drug abuse worker competency and, perhaps some form of certification or licensure as well. As a result, the opportunities for upward or lateral job mobility for the traditional drug abuse worker in treatment programs may be reduced due to intense competition from nurses, social workers and degreed counselors.

Drug abuse workers are at the risk of becoming alienated from the very field they have struggled to develop. To avoid this very real possibility, we must exercise the option of professionalizing the staffs so that they can be able to define their competency as skilled professional workers in their own right, with suitable prestige and access to career growth and performance. NIDA's Manpower and Training Branch has, over the past six years, been developing structures and programs to produce competency-based training and career development opportunities for drug abuse workers. A number of these, hopefully, will serve as building blocks in an effort to assist the drug abuse field and, particularly non-degreed workers in attaining a level of professionalism equivalent to other health services in other fields.

We are attempting to foster this professionalism at a significant and difficult moment for the country and for our group. Inflation, and consequent budgetary pressures as well as generalized public skepticism of government activities are putting pressures on most Federal programs. Our responsibility as professionals and workers in the field is a particularly heavy one. We must be precise and clearsighted in our perception of reality, both the reality of our field--drug abuse-- and the larger realities of the overall national situation.

Those of us who work in the drug abuse field must be realistic and creative in our effort to integrate these two environments and, at the same time, we must be forceful and vocal in communicating to the public and to national leaders the detailed truths of the specialized problems that we are more knowledgeable about than others in the country. This makes it all the more important to have a very clear idea of what we believe to be the correct approach for meeting the training needs for the coming decade. We must determine a clear consensus concerning the options. Let us join together in making wise selections with regard to priorities, because it is very clear that we will have to make difficult choices in the years ahead.

Priority Issues

The National Institute on Drug Abuse efforts in credentialing will focus on three priority areas: credentialing models, demonstration of job competencies, and reciprocity among State credentialing efforts. Each of these priorities focuses back to the primary concerns of quality care and worker competence. NIDA in working with State agencies serves the role of facilitator and convener of task forces to deal with the issues of reciprocity, information exchange, development of demonstration procedures and minority concerns. Credentialing efforts that seek to impact upon the two primary concerns of the Institute will be relatively unique to each State. However, the function/skill data will serve as a common base on which State efforts can build. As has already been seen, even States with existing credentialing programs can make use of the data to further improve the relationship of their credentialing to actual service delivery. The sharing of existing State efforts through the various task forces will minimize duplication of efforts, establish a common data basis for model implementation and ensure that mechanisms for reciprocity are established. There is no single answer to the delivery of quality care. There is no single way for an individual to develop and demonstrate his job competence. An ongoing process, including communication, exchange of resources, and refinement of program efforts, is necessary for the operation of the Institute/State credentialing effort.

CREDENTIALING COAST TO COAST: A DPR UPDATE

by Cynthia D. Kunz

Credentialing: An Overview

The movement to credential drug abuse practitioners is several years old and is based almost exclusively within the separate States. No universal standards or statements of competency have applied to this process and no national timetable exists to mandate the State level development of worker credentialing. Thus, the States have proceeded according to the actions of their respective legislatures, in response to the desires of the treatment service community, third party payers, or in response to the concerns of counselor and professional organizations. There are three key points that should be considered when discussing national perspective on credentialing:

- o States have not achieved a uniform status in credentialing efforts. Approximately 20 States have completed their credentialing system design and another 10 are in various stages of developmental planning. The remaining States either have no plans to credential drug abuse practitioners, have not received authority to undertake such efforts, or are in the earliest phases of feasibility study.

States with completed credentialing systems exhibit a variety of approaches to the assurance of a meaningful credential. Approximately 7 States use the Single State Agency for drug abuse planning as the source of authority to confer credentials; another 5 use a counselor association; still others use independent boards or state departments of health. Categories under which drug abuse practitioners can be credentialed vary widely. Four States credential drug, alcohol and substance abuse counselors discretely; 5 States credential substance abuse or chemical dependency counselors only; several States offer levels of certification reflecting differences in knowledge, skill and experience; and some States are beginning the process of credentialing those drug abuse practitioners who are not necessarily counselors, e.g., prevention workers.

Credentialing: The Meaning of its Diversity

As these variations suggest, the matter of credentialing drug abuse workers is neither simple nor clearly defined, and every effort to credential involves a vortex of motives, desires and intentions on the parts of several groups of actors.

On one level, the movement to credential drug abuse workers represents an effort by duly constituted public authorities, e.g., legislatures, in the interests of the client population. According to this approach, credentialing is undertaken in order to establish some assurance on the part of drug treatment and rehabilitation clients and funding agencies that services will be provided by competent and trainer personnel. The usual methods employed in this approach are:

- o Compulsory licensure - only those drug abuse workers who meet predetermined State qualifications are granted permission by a State agency to hold a license and use particular job titles, e.g., drug abuse counselor. Unlicensed persons are prohibited from practicing in the field.

or more commonly,

- o Mandatory certification - a governmental agency, often in conjunction with professional associations, grants recognition to drug abuse workers who meet certain pre-determined qualifications that are designed to assure worker competence.

Colorado, Hawaii, Nebraska and Nevada use these basic approaches to credentialing their drug abuse workers.

On another level, the movement to credential drug abuse workers represents the effort by professional associations to upgrade their field's standards of practice, and to seek by establishing standards of preparation and experience to which workers must conform. Ideally, this effort has two effects: 1) it establishes the criteria for

successful and competent practice as a drug abuse counselor and 2) it enhances the status of the professional organization and of the field itself. The usual methods employed in this approach are:

- o Voluntary certification - a professional association grants recognition to workers who meet pre-determined qualification.

- o Voluntary registry - a professional association or government agency maintains a list or official roster of qualified workers.

Indiana, Kansas, Louisiana, Maine, Minnesota, North Carolina, Pennsylvania, Rhode Island, South Carolina, Tennessee, Wisconsin and Wyoming use these basic approaches to credentialing their drug abuse workers.

While the primary interest groups in credentialing efforts are usually a public body representing the interests of clients and existing practitioners in the field, other interests may enter in as well. For insurance companies and other third party payers for drug abuse treatment services, efforts to credential counselors represent a form of quality control. Programs with a complete or a majority of staff appropriately credentialed are presumed to have reached a level of competence that entitles them to act as conduits for third party funds, while those programs without credentialed workers are not so entitled.

Issues of professional turf often enter into the credentialing process. In some States, the impetus for credentialing drug abuse workers has involved professional associations that represent health and mental health professions. In several instances, the goal has been to include and subsume drug abuse counseling within the standards of these professions. Most drug abuse counselors regard this as an encroachment and not in the best interests of drug abuse treatment service to clients.

Thus, the precise mode of credentialing drug abuse workers is determined by the unique set of constraints and resources within a given State. The choice of compulsory licensure by a State agency, mandatory certification involving a professional organization, or, voluntary certification and registry by government or a professional body, is one that involves many interests. Clients, client representative groups, existing practitioners, policy and funding agencies and sometimes related health and mental health professionals all have a stake in this process.

Credentialing: Changes in the Past Two Years

Since the winter of 1979, when the research for the first survey of credentialing systems was done, there have been many changes. In a recent DPR survey, some 17 States reported substantial accomplishments that either altered their categorical status or significantly changed the focus of their efforts.

Among the more important of these changes are the following in States with operating credentialing systems for drug abuse workers:

- o New Jersey completed and began implementing its credentialing system.

- o Pennsylvania expanded its existing credentialing system to accommodate drug abuse prevention workers.

- o North Carolina began the planning process for expanding its credentialing system to include prevention workers.

For States in the developmental planning stage, there have also been great strides:

- o Illinois designed and completed a feasibility study and is currently constituting a steering committee for the implementation of a credentialing system.

- o South Dakota studied four existing credentialing systems in nearby States and is currently completing final work on the standards and process it will use.

- o In Wyoming and New Mexico credentialing boards are being planned and constituted.

- o In Georgia and Arkansas committees are at work to design the credentialing system and to establish

evaluation criteria for portfolios respectively.

Accomplishments among States in the preliminary planning phase include the following:

- o Florida has completed an initial feasibility study.
- o California has reconstituted a committee to study the issue of credentialing.
- o Delaware is planning a credentialing workshop and strategy meeting with the assistance of the Career Development Center.

Credentialing: New Efforts - New Issues

DPR's initial survey of 1980 credentialing status revealed progress and accomplishment in many States and in many different areas. In upcoming issues, representative credentialing systems will be examined in depth and detail. We invite your letters and telephone calls suggesting which systems should be so highlighted, and also invite your commentary on a number of emerging issues we discovered in the process of conducting this update survey:

o Grandfathering

In some States, the first years of credentialing, a grandfathering provision was included in the standards to help win the support of existing practitioners and to acknowledge the skills and competence of workers with substantial job histories in the field.

The matter of continuance has quickly emerged as an issue: do grandfathered workers need to maintain their credentials in the same manner as others? And, what provisions are to be made for the counselor with many years of experience but uncredentialed in one State, who moves to another State with a credentialing system? Do grandfathering provisions apply to this case?

o Credential Maintenance

Once a credential has been granted, the mechanisms for keeping it in effect become an issue. Both availability and quality of inservice training and continuing education are of paramount concern here. For example, where are the sources of such intermediate and advanced level learning for drug abuse practitioners? What criteria are to be used for deciding which inservice training and continuing education courses will meet approval?

o Enforcement

For those States with voluntary systems, the meaning of the approval itself has become an issue. While this is a necessary and common problem for emerging professional groups, it is no less of a concern to the drug abuse field. What provisions exist or should exist to ensure that clients are served by credentialed professionals? What provisions are needed to accommodate the case of removal of credentials for a violation of competent or ethical practice?

o Special Practice Areas

The drug abuse field is one in which substantial experimentation and program development has been undertaken over the past several years, and specialty areas of practice have emerged: prevention, clinical supervision, program planning and management and the like.

The drug abuse field is also one in which a fairly impressive history of special population and minority involvement has been established. Many local drug abuse programs working with minority or other special population groups have developed fundamental linkages and specialized practices involving other human service agencies. Operating on the principle that effectively servicing minority or other special population groups requires more than simply treating a drug dependency and must involve the reconstruction of social and emotional supports, these programs have developed a range of necessary and interfacing services, such as vocational counseling, network and support group building, criminal justice and court service counseling, housing counseling and the like. These areas, too, constitute specialty practices that include community organization as requisite skills.

Additional areas of specialty practice include those serving the drug abuse client with other disabilities and problems. Practitioners serving the deaf, the mentally ill, or the client with a history of sexual abuse, for example, have required knowledge and skill areas that go far beyond the common definitions of the drug abuse counselor. The growth of these new specialty areas offers the field new opportunities for upward and lateral career mobility. Hopefully, certifying agencies will devise mechanisms that make accommodations for drug abuse workers who practice in these specialty areas.

STATUS	STATE	CHANGE SINCE 79	EXPLANATION
NO PLANS:	ALABAMA	NO	Voluntary certification for alcohol workers only.
	KENTUCKY	NO	Delivered workshop on credentialing.
	MISSISSIPPI	YES	Credentialing not an issue; substance abuse workers are degreed.
	NEW YORK	NO	Credentialing not an issue supported in the field.
	OHIO	YES	Expecting legislature mandate this year.
	OKLAHOMA	NO	Credentialing for alcohol workers only.
	OREGON	NO	Credentialing not an issue supported in the field.
	UTAH	NO	State licensing authority declined to support effort.
	VERMONT	NO	Credentialing for alcohol workers only.
PRELIMINARY PLANNING:	ALASKA	NO	
	ARIZONA	NO	State legislature has not yet mandated.
	CALIFORNIA	YES	Committee re-established to begin efforts.
	CONNECTICUT	NO	
	DELAWARE	YES	Planning a credentialing workshop and strategy meeting.
	DISTRICT OF COLUMBIA	NO	
	FLORIDA	YES	Completed feasibility study; unsure of field desire for credentialing.
	GUAM	NO	
	IOWA	NO	
	PUERTO RICO	NO	
	VIRGINIA	NO	
	VIRGIN ISLANDS	NO	
	WEST VIRGINIA		
DEVELOPMENTAL PLANNING:	ARKANSAS	YES	Drug Certification Board currently establishing evaluation criteria for portfolios.
	GEORGIA	NO	Credentialing Task Force currently considering models.
	ILLINOIS	YES	Feasibility study completed; currently constituting a steering committee.
	MASSACHUSETTS	NO	
	MONTANA	NO	Planning a Registry using an oral examination.
	NEW HAMPSHIRE	YES	
	NEW MEXICO	YES	Currently seeking to establish a credentialing board.
	SOUTH DAKOTA	YES	Feasibility study completed; currently finalizing standards and process.
	TEXAS	NO	
	WASHINGTON	NO	Alcohol workers credentialing in place; drug subcommittee currently reviewing content/skill areas.
	WYOMING	YES	Certification for Addiction Specialist (5 levels) now being re-designed to use a state-constituted certification board.

STATUS	STATE	CHANGE SINCE 79	EXPLANATION
OPERATIONAL:	COLORADO	NO	Mandatory certification for alcohol and drug counselor, Levels I-III.
	HAWAII	NO	Mandatory Certification for: substance abuse counselor, drug counselor, and alcohol counselor.
	IDAHO	YES	Currently grandfathering existing workers; use examination for new workers.
	INDIANA	NO	Certification for: drug counselor in-service and drug counselor, Levels I-II.
	KANSAS	NO	Voluntary certification for drug counselors and senior drug counselors. Levels I-III.
	LOUISIANA	NO	Voluntary certification for: substance abuse counselor, drug counselor, and alcohol counselor.
	MAINE	NO	Voluntary certification.
	MARYLAND	NO	State Merit System for: Drug Counselor Levels I-IV.
	MICHIGAN	YES	Considering State operated credentialing system; voluntary peer review system in place.
	MINNESOTA	NO	Certification and Registry for chemical dependency practitioners.
	NEBRASKA	NO	Mandatory certification for chemical dependency counselor, Levels I-IV.
	NEVADA	NO	Mandatory certification for: substance abuse counselor, drug counselor and alcohol counselor.
	NEW JERSEY	YES	Credentialing system now in place.
	NORTH CAROLINA	YES	Currently studying credentialing for prevention workers; certification for drug abuse counselors in place.
	NORTH DAKOTA	NO	Certification for: addiction counselor-trainee, master, counselor.
	PENNSYLVANIA	YES	Certification for drug counselors and prevention workers.
	RHODE ISLAND	NO	Certification for drug counselors.
	SOUTH CAROLINA	NO	Voluntary certification for drug counselor.
	TENNESSEE	NO	Certification for: substance abuse counselor, drug counselor, alcohol counselor.
	WISCONSIN	NO	Certification for: substance abuse counselor, drug counselor, alcohol counselor.

RECIPROCITY AGREEMENTS AID CREDENTIALING EFFORTS

by Kay Taube

Through the establishment of reciprocity agreements, States with operational credentialing systems are now beginning to recognize the validity of each other's competency standards for alcoholism and drug abuse workers. Such agreements may represent yet another step towards the development of uniform, national standards of professionalism in the alcoholism and drug abuse fields. Increased professionalism is viewed as a means to attaining the additional stature, recognition and funding (including funding through third party payments), which are deemed essential to the survival of alcoholism and drug services during the 80's.

In response to growing concerns from both consumers and service providers during the 70's, both NIDA and NIAAA encouraged the states to develop credentialing systems for drug and alcohol workers. Credentialing, which may take the form of certification, licensure or a registry of workers, was initially intended as a means of providing professional recognition to the non-degreed counselor. Frequently, this worker has been an ex-addict or recovering alcoholic with work experience in the field, but little or no formal education and training.

Credentialing is now seen as a quality assurance, attesting to the client, the general public and the alcohol/drug abuse field that the worker has achieved at least minimal standards of competence.

A 1978-1979 study of credentialing, conducted for NIDA by Ms. Joy Camp, revealed at least 20 States have credentialing systems in place for drug abuse workers. A more recent NCALI study reports that at least 40 States have implemented credentialing systems for alcoholism workers. (Some of these States credential addictions, chemical dependency, substance abuse or alcohol and drug workers, while others have "alcohol only" certification processes.)

In general, the States have developed their credentialing process in a manner responsive to each State's unique complement of resources and fiscal, legislative and political constraints. As a result, existing certification processes may be voluntary or mandatory, and may be operated by one or more of the following:

- A unit of State government, such as the SSA/SSA, or a licensing or regulatory agency
- A private, non-profit corporation
- A statewide association, or sub-grouping of the association, i.e., The Minnesota Chemical Dependency Association
- A counselors' association within the State

Likewise, each State has devised its own standards and corresponding set of measures to determine who meets these standards. In assessing an applicant's qualifications for credentialing, one or more of the following is usually required:

- Submission of reference letter
- Submission of a portfolio
- Documentation of education/ training experience
- Documentation of practicum and/or work experience
- Peer review of work samples
- Oral interviews
- Oral exam
- Written exam
- Agreement to abide by a code of ethics
- A signed statement that the applicant has not abused alcohol/drugs for a specified time period prior to submission of the application

Due to a wide range and mix of options that may be used to assess an applicant's qualifications for credentialing, many differences between the various State credentialing systems have emerged. Consequently, at a cursory glance, the task of establishing workable reciprocity agreements appears highly unworkable.

"Not so", says Ms. Joanne Potts, Executive Director of the Wisconsin Alcoholism and Drug Counselor Certification Board, Inc. and Coordinator of the Certification Reciprocity Consortium. "Reciprocity agreements can and do work, provided the issue of reciprocity is approached with the right attitude." The attitude she refers to is one

of determination that reciprocity is desired and that an agreement will be established.

Obviously, this attitude has paid off for Wisconsin, and the four States currently making up the Certification Reciprocity Consortium, which was established in 1979. Through the efforts of the Consortium, certification reciprocity agreements now exist between Indiana, Maryland, Michigan, Texas, and Wisconsin. Other States have already expressed interest in joining the Consortium.

In the Western Region, several States with credentialing systems have also developed a mechanism for recognizing certification awarded by other States within that Region. A Task Force, comprised of representatives of credentialing bodies from Wyoming, California, Utah and Nevada, developed the criteria under which transitional certification may be awarded to applicants certified by any of the participating States. After a one year period of transitional certification, applicants must meet the educational/training and testing requirements of the State in which they are seeking certification.

Advantages of Establishing Reciprocity Agreements

What are the advantages of establishing reciprocity agreements? For the alcoholism or drug abuse worker, geographic mobility and corresponding opportunities for professional advancement are enhanced with the knowledge that his/her certification will be recognized by another State. For the client and for the public, reciprocity provides an assurance that a counselor is capable of providing services meeting that State's professional standards. For both the counselor and the certifying body, unnecessary duplication of cost and effort is avoided in recognizing demonstrated competence.

Reciprocity agreements serve to strengthen the validity of a State's credentialing process. Similarly, States with inferior or too stringent standards may opt to alter and improve their credentialing process as they seek reciprocity. Finally, such agreements have the potential of forming a basis for uniform, national credentialing standards.

Establishing a Reciprocity Agreement

How does a certifying body go about establishing a reciprocity agreement? While there is no clear cut answer to this question, the following five guiding phases seem to have emerged:

1. Consideration Phase

It is during the consideration phase that the attitudinal factor described by Ms. Potts becomes important. If the parties involved are not committed to making a reciprocity a reality, then efforts to develop an agreement are not likely to succeed.

Timing may or may not be an issue in determining whether your State's credentialing system is ready to seek reciprocity. Regardless of the newness or the maturity of the credentialing process, it would be wise to consider the following questions in assessing readiness to enter into a reciprocity agreement:

a. What is to be gained by entering into a reciprocity agreement? Always bear in mind that gains should be measured by looking at the agreements ability to meet the expressed needs of not only the State, but also the substance abuse worker and client.

b. What may be lost by entering into an agreement? For example, might the agreement result in a lost labor supply if workers decide to seek employment in a reciprocating State? Could a reciprocity agreement result in a loss of credibility for the State's credentialing process if some existing standards are invalidated?

In most instances, the potential gains of establishing reciprocity far outweigh anticipated losses. If this does not appear to be the case for your State's system, you are probably not ready to proceed with reciprocity.

2. Deliberation Phase

The next step to establishing reciprocity (deliberation) involves the mutual examination of the involved States' competency standards or certification criteria. Standards must be carefully scrutinized to determine similarities, equivalencies and differences in the system. When

differences are noted, a determination must be made as to which of these differences is inconsequential, which substantive, which are negotiable, and which are not.

3. Negotiation Phase

After examination of standards, if both parties remain committed to making reciprocity work, negotiation begins. Compromises, which may be relatively easy to make in negotiable areas, may not be as easily achieved in "non-negotiable" areas. For this reason, it is often desirable to employ an impartial third party, to act as a facilitator when the negotiation phase begins.

4. Approbation Phase

Once tentative agreement is reached as to how reciprocity will operate, representatives generally must obtain formal approval (approbation) for the agreement from their State's certifying body. If members of the respective credentialing bodies have been apprised of progress throughout the consideration, deliberation and negotiation phases, there is less difficulty in obtaining approval. Once required approval is obtained, reciprocity agreements may be signed and implemented.

5. Implementation Phase

Implementation plans are generally developed during the negotiation and approbation phases of the process. An implementation plan should minimally include:

a. The effective date of the reciprocity agreement;

b. A plan for informing people that the agreement exists;

c. A description of eligibility and procedures for obtaining reciprocity certification; and,

d. A plan for resolving unforeseen problems that may arise in awarding reciprocal certification.

States interested in establishing credentialing processes or in developing reciprocity agreements for existing processes have several available resources, including NIDA's Manpower and Training Branch. Ten States (Indiana, Kansas, Minnesota, Nebraska, Nevada, New Jersey, Pennsylvania, South Carolina, Utah and Wisconsin) have been awarded funds, through their State Training Support Program grants, to assume a leadership role in assisting other States in developing credentialing and/or reciprocity agreements for drug abuse workers.

Staff and consultants to the Regional Support Centers and the Career Development Center are able to provide technical assistance on a variety of credentialing issues. For additional information, or to request technical assistance, call or write to Dr. Jerome A. Contee at the Career Development Center, 11325 Seven Locks Rd., Suite 231, Potomac, Maryland 20854.
Phone: (301) 983-9520.

PRIMARY HEALTH CARE PROVIDER TRAINING WORKSHOPS

by George H. Ziener

In 1979 a series of task force meetings were held with representatives from the Bureau of Community Health Services, the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), and its Institutes (National Institute on Drug Abuse-NIDA, National Institute on Alcohol Abuse and Alcoholism-NIAAA, and National Institute for Mental Health-NIMH). The purpose of these meetings was to identify ways to increase the skills and knowledge of primary health care providers in alcohol, drug abuse and related mental health (ADM) issues. The task force participants felt that in many places, particularly rural areas, primary health care providers such as family physicians and public health nurses were the first persons that came in contact with persons having drug and/or alcohol problems. Most of these health care providers have never received specific training in ADM areas. As a result, their ability to recognize, deal with, or refer persons suffering from alcohol or drug problems is generally based on their outside learning rather than on a consistent body of knowledge and resources about substance abuse.

The evident need to increase the skills of primary health care providers resulted in two specific program efforts:

a) The development by the National Center for Alcohol Education of a model curriculum for primary health care providers to provide a continuing education workshop on ADM topics.

b) The funding of State agencies to develop and deliver a continuing education workshop designed to involve Alcohol, Drug Abuse, and Mental Health State Authorities; Community Health Center clients; local medical and nursing associations and other State and local health agencies. Each ADAMHA Institute would fund a number of pilot States through their respective State Manpower/Training Programs.

The primary concern of the task force was to provide for the specific ADM needs of primary health care providers through an interagency effort that would use the National Center for Alcohol Education (NCAE) curriculum as a resource but would be developed as a pilot effort led by the specific State Agency funded: (NIDA - Single State Agencies; NIAAA - State Alcoholism Authorities; NIMH - State Mental Health Authorities). This approach would allow each Institute to focus on its specific programmatic concerns while developing a cooperative pilot effort that could be shared with other States and other health service agencies.

The National Institute on Drug Abuse modified six State Training Support Program Grants to act as model States in developing and delivering a Primary Health Care Provider Workshop on Alcohol, Drug Abuse and Related Mental Health Issues. Selection was made after discussion with the National Committee and a number of individual States. The primary factors (in order of importance) included: existing training/education efforts with the medical/health care community (especially interagency efforts); capability to provide CEU's for primary health care personnel; geographic distribution (at least one State in each region); willingness and ability to serve as a lead State by developing and delivering at least one workshop. The six States funded as lead States are:

Arkansas (SW)	Michigan (C)
Arizona (W)	Mississippi (SE)
Illinois (C)	New Hampshire (NE)

Michigan was chosen as an additional State in the Central Region because it served as the test State for the National Center for Alcohol Education (NCAE) curriculum and could provide information on long-term evaluation of those curriculum materials. Because these programs will serve as models for use by other States, the specific structure of each ADM pilot workshop will be documented. In order to increase the replicability of these pilot ADM workshops, the NIDA lead States will participate in two task force meetings; one before the workshops are developed and delivered, and the other after the workshops have been developed.

The objective of the first task force meeting is for the lead States to share ADM training resources presently available including: New Hampshire's Physician Training Program, the NCAE Primary Care Provider Curriculum, the American Hospital Association Training Program on Alcoholism. Based on available resources each State will then produce an activity plan leading to final development and delivery of one or more ADM workshops. In addition, the task force will outline an evaluation strategy to be incorporated into each model workshop that will provide feedback for refining the model workshops.

The objective of the post workshop task force meeting is for the lead States to document their workshop structures; to review evaluation information; and to develop replication and dissemination strategies for use by other States in the development of their own ADM Workshops.

While the entire ADM Workshop effort has long-term interagency implications, the present NIDA effort focuses on assisting States in the development of models that can serve as resources to other States and not in continued funding of workshop deliveries. The entire effort, however, serves as a major example of Federal/State cooperation and interagency planning. The resulting models will impact a population of healthcare providers who serve as a primary interface with persons having alcohol, drug abuse and related mental health needs.

PRE-WORKSHOP TASK FORCE MEETING

OBJECTIVES:

1) To provide lead States with information and copies of ADM Workshop resources including: New Hampshire's Physician Curriculum, NCAE Primary Care Curriculum; American Hospital Assn. Alcohol Training Program.

2) To exchange among lead States their initial needs, curriculum development, recruitment and delivery plans as well as to provide information on the content and status of the related NIAAA and NIMH programs.

3) To have each lead State develop an activity plan leading to development and delivery of an ADM Workshop.

4) To develop evaluation guidelines that will provide each State with information that can be used in improving the workshops and assist in developing replication strategies for use by other States.

5) To develop an agenda and dates for the post workshop task force meeting.

AUDIENCE: NIDA Lead States - Arizona, Arkansas, Illinois, Michigan, Mississippi, New Hampshire; interested RSC representatives; NIDA MTB Staff; representatives from NIAAA, NIMH, BCHS, NCAE, NDAC, CDC (as necessary). MTB will chair the Task Force.

Time: Minimum of 3 days early in December or January.

Location: Washington, D. C. - Parklawn Building.

NATIONAL TRAINING SYSTEM NEWS

The following newsletter to the field was written by Dr. Lonnie E. Mitchell, Acting Director, Training Division, National Institute on Drug Abuse.

Drug Program Report wishes to share this letter with its readers.

Dear Colleague:

We would like to share with you the initiatives the Manpower and Training Branch expects to undertake during this fiscal year.

1. Access to Research Careers

   This program will focus on the recruitment and funding of ethnic minority persons who will pursue research careers in the drug abuse field. This initiative will be tracked by Ed Morgan.

2. Black College Initiatives

   The Black College Initiative is developed in response to the recent Presidential Executive Order which mandates that the Federal Government create and make certain responses to the needs of predominately Black colleges. This initiative will be tracked by Dr. Mitchell.

3. Division of Community Assistance Training Project

   This project will provide specific training to SSA monitors who track and monitor the DCA funded programs through the SSAs. Avraham Forman will track this project.

4. NTS Evaluation

   The National Training System will be under evaluation during fiscal 1981. A contract will be let and results from this initiative are expected in late Spring 1981. Sol Silverman will track this program.

5. Independent American Indian Training Initiative

   This initiative will be a response to an unsolicited proposal from a Native American group who proposes to develop a training response that will specifically handle the needs of American Indian clients. Clifton Mitchell will track this initiative.

6. Prevention Training and Material Development

   The prevention effort which is being expanded in fiscal '81 calls for a new effort in the development of training activities for prevention workers and the creation of specific materials that will support the training process. Avraham Forman will track this initiative.

7. Bureau of Community Health Services

   A model project involving approximately 6 States will be created through the STSP activities to develop primary care training activities. Dr. Mitchell will track this initiative.

8. Reciprocity Task Force (Credentialing)

   A Reciprocity Task Force in the area of drug abuse worker credentialing and certification will be established and a model utilizing 10 States through the STSP mechanism will be developed. Dr. Mitchell will track this initiative.

9. Director's Forum

   The Director's Forum is a new program sponsored by the Manpower and Training Branch which will provide staff development opportunities for NIDA and other closely related agencies and/or offices of ADAMHA. The Forum will feature guest speakers who will make presentations on a variety of subject areas. Continuing Education credit is being explored. Avraham Forman has the initiative on this activity.

10. Professionalizing the Drug Abuse Field

    The drug abuse field unlike the areas of alcoholism and mental health has suffered from what might be considered an image of not being professional, and the workers in the drug abuse field do not realize

the same status or equal status as a parity concept with other service delivery professionals. This effort will be designed to provide that base and status.

For further information regarding these efforts, please feel free to call (301) 443-6720.

Sincerely,

Lonnie L. Mitchell, Ph.D.
Acting Director
Division of Training

The Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) is accepting applications for Faculty Fellowships, as one element of an ADAMHA Minority Access to Research Careers (MARC) Program. Awards will be made by each of the three ADAMHA Institutes to selected faculty members of four-year institutions whose student enrollments are drawn substantially from ethnic minority groups, for advanced research training in areas relating to alcoholism, drug abuse, and mental health. Individuals may apply for support for a period of advanced study and research training in graduate departments and laboratories, either as candidates for the Ph.D. degree or as investigators obtaining post-doctoral research training, in specified areas related to alcoholism, drug abuse, or mental health.

Additional information about the Faculty Fellowship Program may be obtained by writing or calling one of the staff persons listed below whose Institute affiliation corresponds to your particular research interest:

National Institute on Alcohol Abuse and Alcoholism:

Nathan Rosenberg, Ph.D.
Division of Resource Development
5600 Fishers Lane, Rm. 14C-17
Rockville, MD 20857
(301) 443-4640

National Institute on Drug Abuse:

Edward T. Morgan, Jr.
Division of Resource Development
5600 Fishers Lane, Rm. 10A-46
Rockville, MD 20857
(301) 443-3640

National Institute of Mental Health:

Ronald Schoenfeld, Ph.D.
Division of Manpower & Training Programs
5600 Fishers Lane, Rm. 8C-02
Rockville, MD 20857
(301) 443-3856

Applications must be submitted to the Division of Research Grants, National Institute of Health, Westwood Building, Room 240, Bethesda, MD 20205.

The Manpower and Training Branch has developed a Resource Information Bank (RIB) which disseminates microfiched courses to the STSP grantees. The courses include state-developed packages which have proven to be a very valuable resource to the National Training System. The Branch is also searching for material to be included in the RIB, and would appreciate receiving either microfiched or hard copies of courses and other training materials developed by your State.

You may obtain a list of courses that have been selected for the RIB library by sending a request in writing. Requests will be filled in the order of receipt until the supply is exhausted.

If you would like to request microfiched courses from the Resource Information Bank, please contact:

Ms. Lillian G. Marks, Program Assistant
Manpower and Training Branch
Division of Resource Development
5600 Fishers Lane, Room 10A-46
Rockville, MD 20857
(301) 443-4922

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Mr. Frank Nelson, Administrator of Florida's Department of Health and Rehabilitative Services Drug Abuse and Mental Health Program, was one of the 1980 recipients of NIDA's "Pacesetter Award". The award is given out annually in recognition of outstanding achievement in research, treatment, prevention, and administration.

The presentation was made at the National Alcohol and Drug Conference on September 15, 1980. The award recognizes Florida as the first State to develop a monitoring manual to serve the drug abuse, alcohol, and mental health systems within the State.

The Career Development Center, along with other National Training System Components, has an extended history of valuable service to the drug abuse field. Among its past accomplishments has been the publication of Drug Program Review as an organ of communication for the field.

We at the Center feel that this is an appropriate time to review, analyze and index all of the previous Drug Program Review publications and to offer such an index to readers of Drug Program Report. It is hoped that this index may be a useful reference and research tool for you.

The Editor

CUMULATIVE INDEX BY SUBJECT AND AUTHOR

The Index encompasses all the articles since the inception of Drug Program Review in 1972. Articles have been placed under subject headings and cover categories generally familiar to the National Training System. The subject headings are alphabetical. Entries include the title of the article, the contributing author's name, the volume, number of the volume, page(s), month and year of publication.

Sample Entry:

DRUG ABUSE TREATMENT -- (Subject Heading)

New Light on Correctional Rehabilitation:

Youthful Drug Offenders Live Together in Innovative Therapeutic Community. D. Morgan. 1:2, 14, MY 72

The concluding references for the sample entry mean the article would be found in Volume 1, Number 2, page 14, May 1972. If the entry continues on other pages, the symbol + follows the page number. Authors' names have been included in each entry if the author was identified with the article. In entries where the identity of the author is not known, the article was attributed to the sponsoring agency. Hence, articles are listed in The Authors Index by the Career Development Center, the Center for Human Services and the National Institute for Drug Programs. The Authors Index is included at the end of the Subject Index.

The following volumes listed in the Index were printed without dates:

Volume 2, Number 2
Volume 2, Number 3
Volume 3, Number 1
Volume 3, Number 2

A complete list of the reference volumes appears at the end of this Index.

The Career Development Center has a limited number of back issues that are available upon request. Library copies are available for loan from the Career Development Center.

DPR SUBJECT INDEX

ACADEMIC LINKAGES

The Continuing Education Program
A. Y. Pointer, 8:1, 8+, F 80

Increasing Professional Development Options: CDC's Goal. 8:1, 2, F 80

A Model CDC Effort - The Governor's State University Program. E. Vasquez. 8:2, 14+, JE 80

New Jersey's Innovative Strategy for Linking Drug Abuse Training with Higher Education. 8:1, 11+, F 80

BOOK REVIEWS

Drug Program Reference Work, The National Directory of Drug Abuse Treatment Programs 1972. 1:3, 27, D 72

Black Tracks. By Floyd "Bunky" Miles. 1:4, 17, MY 73

Bibliography on Drug Abuse: Prevention, Treatment, Research. Human Services Press. 2:1, 15, AG 73

Publication Service: The Drug Abuse Council. Public Policy Series, Monograph Series, Handbook Series, Books. 2:1, 28, AG 73

Career Development Center Publications 8:2, 17, F 80.

CAREER EXCHANGE

Career Exchange. Presented in the following volumes were descriptions of job opportunities and job applicants or people available throughout the country. Initially Career Exchange provided information on jobs for drug abuse workers. Later the emphasis included related areas.
1:1, 33, JA 72; 1:2, 33, MY 72;
1:4, 33, MY 73; 2:1, 32+, AG 73;
2:2, 32+; 2:3, 32+;
3:1, 32+; 3:2, 32+;
*4:1, Back Page, JA 76.
*Article explaining the discontinuance of the Career Exchange Feature.

THE CONTINUING EDUCATION PROGRAM

Professional Development with a College Credit Option: The Continuing Education Program. 6:1, 3, AP 78

The Continuing Education Program. A. Y. Pointer. 8:1, 8+, F 80.

CREDENTIALING

The Ex-Addict in an Employment Trap. Center for Human Services. 1:1, 27, JA 72

One of a Kind Degree. 1st Graduation at National Institute for Drug Programs. 35 Students Received Associates of Arts Degree in Drug Program Management and Supervision. M. Dodge. 2:1, 16, AG 73

Unlocking the Future: Curriculum Development, Regional Training Center, Metropolitan Training Center, Credentialing Model. 2:3, 23+

Program Certifies Drug Abuse Workers. 2:3, 30

Sorting the Issues: Credentialing. S. Steinberg, A. L. Batista; A. S. Bisconti, I. L. Gomberg. 3:2, 5+

Career Development Barriers: Arrest and Conviction Records History of Drug Abuse and Related Impediments to Employment: Issues in the Credentialing and Employment of Drug Abuse Workers. S. Steinberg, E. A. Confrey, A. L. Batista. 4:1, 11+, JA 76

The National Institute on Drug Abuse: It's Involvement in Drug Worker Credentialing. G. Ziener. 4:1, 27+, JA 76

A Review of Credentialing Issues in Substance Abuse. B. Staples. 4:1, 33, JA 76

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Credentialing: A Handbook for Substance Abuse Workers, We Hear What You Say About the Issues. 6:2, 3, AG 78

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The NTS Career Development Center. E. Vasquez. 8:2, 8+, JE 80

A Model CDC Effort - The Governor's State University Program. E. Vasquez. 8:2, 14+, JE 80

DRUG ABUSE CURRICULUM DEVELOPMENT

Religion's Role: Pentacostals Demonstrate the Effectiveness of a Religious Approach to Drug Addiction. Article originally appeared as "The Role of Religion in the Treatment of Opiate Addiction, in Major Modalities, in the Treatment of Drug Abuse. L. Brill and R. Lieberman, Editors. J. Langrod, H. Joseph, K. Valdes. 2:2, 17+

Unlocking the Future: Curriculum Development, Regional Training Center, Metropolitan Training Center, Credentialing Model. 2:3, 23+

In the Frying Pan: New York Served by Metropolitan Center. 2:3, 28+

The NIDP Model of Education for Career Development. W. McEwan. 4:1, 24+, JA 76

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Why Are We Here? NIDP Trainees Find the Answer. 1:2, 7, MY 72

New Light on Correctional Rehabilitation: Youthful Drug Offenders Live Together in Innovative Therapeutic Community. D. Morgan. 1:2, 14, MY 72

Good News - Ex-Addict Earn College Credit and Advance on the Job. 1:2, 22, MY 72

Putting it All Together: Drug Problems in Community Health Centers. M. Ratner. 1:2, 24, MY 72

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Mile Square Health Center. M. Ratner. 1:3, 7+, D 72

Mile Square Drug Abuse Program. M. Ratner. 1:3, 15, D 72

Discrimination and the Addict. Prepared for Drug Program Review from a paper entitled "Notes Toward a Federal Theory of Addict Rehabilitation" delivered before the 1st National Conference on Discrimination and the Addict, Mayflower Hotel, Washington, D.C. on June 16-17, 1972. L.R.S. Simmons and M.B. Gold. 1:3, 28, D 72

In and Out. Day Top: A Therapeutic Community with an Open Door at the End. 1:4, 2, MY 73

New Jersey: The Good is Rehabilitative Rather than Revolving-Door Therapy. National Institute for Drug Programs. 1:4, 14, MY 73

Why Drug Abuse Education is Failing in America. A paper originally read before the 30th International Congress on Alcoholism and Drug Dependance, Amsterdam, Holland, September 1972. P.G. Hammond. 1:4, 19, MY 73

Mending Lives: DDI Heops Communities Achieve Mental Health Through Community Psychology. M. Ratner. 2:1, 3+ AG 73

Legal Services as a Tool in Treating the Addict. An article reprinted in DPR from the American Journal of Psychiatry, MY 73. J. Lowinson, J. Langrod, L. Alperin. 2:1, 23+, AG 73

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Classics Come to Baltimore: Running A Methadone Program is More Than Giving Out a Tang. M. Ratner. 2:2, 2+

Methadone Maintenance Treatment Five Years Later - Where Are They Now? - A condensation of Methadone Maintenance Treatment Five Years Later - Where Are They Now? American Public Health Assn., Epidemiology Section, Atlantic City, NJ Nov. 13, 1972. F. R. Gearing. 2:2, 25+

The New Energy Within: Army Develops Strategies to Combat Drug Abuse. M. Ratner. 2:3, 3+

Mission Possible: Fort Meade Program Confronts Alcohol and Drug Problems. M. Ratner. 2:3, 11+

DRUG PROGRAM MANAGEMENT AND SUPERVISION

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Prisoner's Dilemma Can You Trust Your Opponents. 1:1, 23, JA 72

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Why Are We Here? NIDP Trainees Find the Answer. National Institute for Drug Programs, Center for Human Services & Webster College. 1:2, 7, MY 72

Second Year. NIDP Begins It's Second Year Program. 1:3, 30, D 72

Business and Labor Leaders Educate Industry (PACT, Provide Addict Care Today). 2:1, 15, AG 73

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Issues in Agency Manpower Development. W. E. Link. 7:1, 14+, F 79

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Needed: New Books on Drug Programs, Telling Who, Why, Where, When, How of Managing a Drug Program. N. Suniewick. 1:2, 24, MY 72

Addicts and Drug Abusers. Reviewed by N. Suniewick. 1:2, 25, MY 72

Synanon: The Tunnel Back. L. Yablowsky. Reviewed by N. Suniewick. 1:2, 25, MY 72

Addicts and Drug Abusers, Current Approaches to the Problem. Edited by N. Strauss. Reviewed by N. Suniewick. 1:2, 26+, MY 72

So Fair a House: The Story of Synanon. D. Casriel. Reviewed by N. Suniewick. 1:2, 27, MY 72

Dealing with Drug Abuse: A Report to the Ford Foundation. The Drug Abuse Survey Report. Foreword by McGeorge Bundy. 1:4, 29, MY 73

The Treatment of Drug Abuse. American Psychiatric Assn. 1:4, 29, MY 73

The New Professionals. Edited by Ronald Gross and Paul Osterman. 1:4, 29, MY 73

Bakers Dozen: 13 Basic Publications for the Drug Worker. Annotated by Joe Vignone. 2:1, 29+, AG 73

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The NIDP Model of Education for Career Development. W. McEwan. 4:1, 24+, JA 76

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Unicultural Adaptation of NDAC Training Materials: The Chicano Population. R. Garcia. 7:1, 24+, F 79

The Starting Point - Career Development. C. Davis & J. Mandel. 8:2, 4+, JE 80.

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